JOURNAL OF INTERNATIONAL AND COMPARATIVE SOCIAL POLICY
2018, VOL. 34, NO. 2, 140–150
https://doi.org/10.1080/21699763.2018.1472135

The Portuguese stakeholders' perspective on social investment and quality assessment in LTC

Alexandra Lopes and Isabel Dias

Sociology Department, University of Porto, Porto, Portugal

ABSTRACT

There has been quite a considerable amount of debate over the last decade about the importance of quality assessment in the field of LTC provision in Portugal, framed by the discourse on social investment. In a context of limited resources, care providers are pressured to demonstrate creation of value. Quality assessment becomes one of the paths to demonstrate worthiness. This, however, has not translated into standardised protocols of evaluation of impacts and quality in particular. The question has been asked why is that? In this article we contribute to answering this question by looking at the discourses of stakeholders on the topic of social investment and quality in LTC. Overall there is a discourse that acknowledges the importance of assessing investments and quality as a reliable proxy to measure return on investments, although there is a general difficulty in translating social investment and the quest for quality into specific examples and tools.

ARTICLE HISTORY
Received 16 November 2017
Accepted 30 April 2018

KEYWORDS
Social impacts; quality assessment; long-term care; Portugal

1. Introduction

As the population ages, and despite the historical familialist orientation of the welfare state model in place in Portugal as a Southern European Welfare State (Petmesidou, 2018; Saraceno, 2017), a growing number of Portuguese older adults are being cared for resorting to formal services of long-term care (LTC), either in residential facilities or at home with the help of formal care services (EU, 2012). Expansion of formal care services has been slower than needed and desired largely because of the economic crisis affecting the country for the last decade, with the consequent fiscal austerity influencing the development in core areas of the welfare state (Pereirinha & Murteira, 2016). This general policy environment however has also opened some room for the debate about how to put to best use the scarce resources available. Confronted with cuts in available funding, Portuguese LTC service providers, the majority of which are non-governmental organisations funded by the Social Security Office, have been pushed into a rather competitive environment. The pressure in the last 10 years has been put on the need to demonstrate actions funded by public funding are worthy and candidates need to show results. This mirrors a policy orientation from the central government that has been aligning with

CONTACT Alexandra Lopes aslopes@letras.up.pt Sociology Department, University of Porto, Via Panorâmica s/n, Porto, 4150–564 Portugal

the overall arguments of the social investment policy paradigm (Midgley, Dahl, & Wright, 2017; Morel, Palier, & Palme, 2012).

In the specific field of LTC, the importance of the quality of care provided can be argued to be a major determinant of the quality of life of those using the services (Birren, Lubben, Rowe, & Deutchman, 2014; Bowling, Banister, Sutton, Evans, & Windsor, 2002; Bravo, De Wals, Dubois, & Charpentier, 1999; Kane & Kane, 1988). And quality of life, in itself can be argued to be a key dimension of impact of care provision. In some countries this consensus has been translated into regulations that have been implemented with the objective of improving the quality of care provided to older dependent people requiring assistance with activities of daily living (Mor, 2005; Mor, Angelelli, Gifford, Morris, & Moore, 2003). In Portugal this has been one of the preferential aspects of demonstration of worthiness of LTC services in public discourses. Both the regulator and the providers have been emphasising the need to guarantee that money spent on care provisions offers good quality of care. This discursive emphasis however has had a shy expression in real terms, with the emergence of regulations being limited and the definition of quality assessment guidelines remaining vague and with little practical consequences.

In this article the intention is to contribute to the understanding of the underlying reasons for the limited definition of quality guidelines and for the limited implementation of quality assessment mechanisms in Portugal by looking at the discourses of stakeholders on the topic of social investment and quality in LTC. The paper draws on the views of some selected stakeholders directly involved in the provision of formal care services and some interest groups representing users of services and informal carers.

The broad conclusion of the work carried out points to a resilient attitude from the regulatory body towards quality assessment that emphasises material aspects and objectively measurable health outcomes. Providers of services are unhappy about the regulations in place to assess quality that they consider bureaucratic and out-of-touch with the reality of care provision. User-centred approaches are acknowledged as relevant for quality assessment but there is a sceptical attitude when it comes to the implementation of tools to measure user's opinions, preferences and experiences. Despite that, all providers consider they are currently providing high quality care and having significant impacts in the quality of life of their users, although not measuring them. Measuring quality by means of formal protocols is not seen as a necessary step to assess quality of services provided and impacts of care in quality of life. Quality is primarily defined as comfort, happiness and meaningful relationships with carers. These are considered as subjective dimensions of the act of care delivery that when taking place are manifest, easily seen and therefore not requiring specific standardised protocols to measure it. Standardisation is very much associated to the existing regulations that view quality only as technical requirements.

Overall these point to the following central aspects to be analysed in the article: What are the definitions of quality of care for the different stakeholders? Is their approach reproducing the regulatory framework therefore emphasising resources allocated to care and technical capacity of response to needs? Is the definition of quality of care aligned with the common approaches of health care assessment and focused on outputs of care delivery against goals set in care plans? Or is it more focused on a user's-centred approach? How do the different stakeholders consider one can assess quality drawing on their chosen definition of quality? And how do they articulate the concept of social investment with the need to measure quality in care provision?

https://doi.org/10.1080/21699763.2018.1472135 Published online by Cambridge University Press

2. Methodological considerations

This article uses mainly qualitative data, and is a single case study (Yin, 2014). We use the results of a focus group interview as the core source of qualitative data. Participants in the focus group, in a total of 6 people, included professionals coming from: (i) one non-profit representing informal carers and providing counselling and lobbying; (ii) one non-profit acting on behalf of the rights of older people; (iii) one non-profit representing Alzheimer patients and their families; (iv) the main provider of home-help care in the North region of the country (non-profit); (v) the main provider of residential care in the North region of the country (non-profit).

The data was collected in February 2017 at the University of Porto within the research work carried out under the SPRINT project.[1]

Participants were asked about general principles on how to assess/evaluate the impacts of existing arrangements in the country on LTC funding and provision. They were also asked about how they assess their own activities from the perspective of the impacts they have for different actors in society and focusing in particular on the topic of quality. The focus-group check-list also included the collection of views on the concept of social investment applied to LTC. The interview was done in the same format as in other countries as this should help in ensuring an option also for a comparative analysis of stakeholders view upon social investment.[2]

The focus group had a total duration of 90 min and it was moderated by the first author of this paper. A research assistant was also in the meeting but had no direct participation in the discussion rather securing note taking. All participants were briefed about what a focus group is and about the objectives of this particular focus group. Informed consent forms were handed and signed by all participants. The discussion was audio taped with the consent of all participants and later transcribed. The focus group was run in the native language of participants, Portuguese.

Analysing the focus group was done by searching for viewpoints especially related to social investment and quality of care. In this article we present and discuss the findings concerning the specific topic of social investment and quality in LTC and we draw some implications from that in what concerns the place of social investment and quality assessment in LTC in Portugal.

3. LTC in Portugal: setting the background for the discussion on quality assessment and social investment

This section aims to set the scene for the analysis of the qualitative data from the focus group interview. Long-term care (LTC) is understood in this paper as comprising all care services and benefits for old people requiring support in essential facets of daily living as a consequence of illness, both physical and/or mental. However, the preferred term in Portugal to describe these care services has traditionally been social care. This is mostly the consequence of the historical distinction between health care and social assistance. Portugal, similar to other South European countries, has a specific combination of universal coverage in health care with a social insurance system for social protection in old age (pensions and social care) (Saraceno, 2017; Petmesidou, 2018; Rhodes, 1997). LTC for older people requiring assistance in activities of daily living, in cash or in kind, has been

https://doi.org/10.1080/21699763.2018.1472135 Published online by Cambridge University Press

traditionally accommodated under the Social Security Ministry and involves only social care services. More recently, a parallel system has been created, integrating social care and health care. In 2006 a national structure coined as LTC Integrated Network was launched to manage the provision of services that integrate social care and health care and that are jointly funded and coordinated by the Ministries of Health and Social Affairs along the lines of a care continuum approach and focusing on rehabilitation. It is a coordination mechanism focused on rehabilitation after hospital discharge. In this article we shall be focusing on LTC as social care since it represents the lion share of the formal system of provision of care to dependent elderly in Portugal. For a more detailed discussion on the traits of LTC in Portugal from an institutional design perspective see Lopes (2017).

Overall, the Portuguese welfare state has followed a model of development in all areas of provision that require the delivery of care services more or less aligned with the Bismarkian approach. This means it has traditionally emphasised income protection mechanisms with the state showing little interest in expanding coverage of public servicing. The absence of infrastructures of care has been historically compensated by the assistance offered by non-profit organisations with a religious Catholic foundation. In the turn of the century, and while confronted with increasing pressures from an ageing population, but without the inclination or the financial capacity to implement a full-fledged public LTC system, the policy option was to turn to the existing institutions providing assistance and integrating them in a care provision system regulated by the state. To expand services, a private/public mix centred on public subsidies to non-profit institutions was built up in the late 1980s. The argument put forward in the fundamental legislation defining the LTC services sector is that the needs for social services could be and should be satisfied as a result of the organised generosity and altruism of the civil society and not only by the direct intervention of the State, and that the State should support and create the conditions for the non-profit institutions to operate, namely by means of funding and regulation (Lopes, 2013). The last two decades have seen a considerable and sustained growth of the non-profit sector. From the roughly 1500 institutions registered in 1983, this has grown to a total of 5080 in 2015.[3] Services and facilities available to the elderly are diverse: day-care centres, homebased services (home help), nursing homes, as well as residential care (protected flats) and family accommodation (foster family care). The last two have seen a very marginal development. Day-care centres on the other hand are not only for those older people requiring assistance but are often used as leisure centre by individuals that remain fully autonomous. When discussing quality in LTC in this article we will be considering in particular nursing homes and home-help services given these are currently the main settings where LTC provision takes place in the formal sector (Table 1).

Provision has been increasing over the last decades which contrasts, at first sight, with the overall trend towards retrenchment of the welfare state across Europe and also in Portugal in other areas of social protection (Pereirinha & Murteira, 2016). This doesn't necessarily mean there is a proportional increase in public expenditure in LTC that remains one of the lowest in the European Union with 0.23% of GDP for LTC Health and 0.73% for LTC social in 2015.[4] In what concerns the funding mechanism for the provision of care, the system rests on a mixed model of public funding and private out-of-pocket payments based on means-testing.

https://doi.org/10.1080/21699763.2018.1472135 Published online by Cambridge University Press

Table 1. Trends in LTC service provision between 1998 and 2014: nursing homes and home-help care.

	Number of available places nationwide (Usage rate in %)					Coverage rates per 100 persons nationwide			
						65+		80+	
Type of care service	1998	2000	2005	2010	2014	1998	2014	1998	2014
Nursing Homes	49,059 (n.a.)	55,863 (95.3)	60,884 (97.2)	71,261 (95.3)	89,666 (91.5)	3.07	4.29	14.87	15.28
Home-help	38,022 (n.a.)	48,734 (94.3)	73,575 (85.4)	90,570 (83.9)	1,04,551 (73.9)	2.38	5.01	11.52	17.82

Source: Carta Social data, available at www.cartasocial.pt (author's calculations) and Instituto Nacional de Estatística, National Estimates on Population by age groups, 1998–2014 available at www.ine.pt
Notes: n.a. Data not available.

4. Quality assessment in Portuguese LTC

There has been some debate over the last decade about the importance of quality assessment in the field of LTC provision in Portugal. Quality remains, however, as a fuzzy concept that is sometimes presented as a management issue, other times as a characteristic of the performance of professionals and still other times as the satisfaction felt by users (Paúl & Fonseca, 2005), all in all a three-fold approach aligned with the classical model of Donabedian on the categories from where to extract data to measure quality: structure, processes and outcomes (Donabedian, 1988).

In the literature on quality of care we find many and varied approaches, from those with a narrower focus emphasising subjective dimensions of user's satisfaction to broader approaches that include both subjective and objective aspects. Despite this diversity of approaches, it is obvious that quality of care is a multidimensional and dynamic concept that can be understood differently by different stakeholders, that is sensitive to life course conditions and to cultural contexts (Vaarama, Pieper, & Sixsmith, 2007). Irrespective of the approach, the common element across authors is also the recognition that well-being and quality of life of older frail people is a desirable outcome of care provision and that quality in care provision can help in supporting this.

One can safely say that quality of care is a topic that has remained absent from the regulatory framework of LCT in Portugal, and to a large extent this can be a side-effect of the chosen model of provision based on the quasi-monopoly of provision by the non-profit sector. In its path of privatisation of care provision the Portuguese State has been progressively relinquishing its role as social regulator (Ferreira, 2010). At present, the State acts primarily as a funding body and a licensing body for accreditation of providers. It has no interference in operational issues and in its role as supervision agent it limits inspections to assessments of technical requirements of facilities to keep licenses active. In this sense, quality is very much confined to the measurement of existing material resources in care facilities and to ratios of staff to users. Compliance with the minimum standards defined is sufficient for getting a license to operate as care provider and to keep that license after routine inspections.

The non-profit sector, in turn, has traditionally shown little interest in implementing standard routines of quality control that can be disseminated and used to assist candidate users in their choice of providers. Some authors offer tentative explanations suggesting this is either because it operates as a monopoly or because of ideological orientations towards care, still very much embedded in the Christian doctrine of charity and assistance, and not in a culture of social rights (Lopes, 2017).

https://doi.org/10.1080/21699763.2018.1472135 Published online by Cambridge University Press

This contrasts somehow with the routines of quality assessment that were introduced in the branch of the LTC system operating under the rehabilitation services launched in 2006. Here, most likely because of the integration of health care and social care, routines of quality control typical of health care settings have been introduced and enforced by specific legislation. Among the dimensions of quality assessment in place we find: assessment of admission times; assessment of care outcomes against envisaged care plan; and regular surveys among users and their families to assess levels of satisfaction.

5. The social investment debate as a framework for discussions on quality of care in Portugal

In Portugal, the discourse on Social Investment has been very much associated to that of the role of Third Sector organisations in the overall system of welfare provision and to the need of finding funding alternatives to public financing. Some argue for this as a movement towards emancipation for the sector itself. Others see this as the most promising path to face the consequences of the budgetary cuts and the fiscal austerity imposed by the economic crises. In any case, it was within the argument of financial independence and diversification of the Third Sector that the interest in Social Investment has showed up in Portugal. The creation of some public bodies such as the Social Investment Lab (SIL) with a mission of assisting non-profits in attracting private investment, has been helping in spreading the idea that in order to be funded and successful when applying for funding, an organisation has to demonstrate its activities/services deliver a proven impact.

Social investment applied to LTC involves the identification of worthy investments in LTC considering the balance of contributions and benefits expected for society as whole, for the State and for individuals and families (Lopes et al., 2017). Phrased in these terms, social investment involves the consideration of the relationship between resources allocated to the provision and the outcomes of the provision of LTC in view of securing that LTC arrangements deliver a proven social impact. Ways to measure investment in LTC involve, among other things, considerations on quality of care and the search for ways to measure and quantify quality of care as a condition to achieve quality of life. Three distinct dimensions have been addressed in the literature: how to define quality; how to measure/assess quality; how to assure quality. These three dimensions can be thought of as somehow sequential, since how you define quality will lead to the selection of tools to measure it against empirical evidence and this in turn will feed into the development of mechanisms of care provision aligned with the envisaged goals of quality (Vaarama et al., 2007).

6. Quality assessment in LTC: from vague rhetoric to effective management tools – stakeholders' views

Quality measurement in LTC presents many challenges even in the more regulated settings with routine protocols of quality assessment. In Portugal this is further aggravated due to the lack of a uniform definition of quality and regulatory influences that emphasise measurement only of poor quality confined to technical requirements.

In the focus group discussion, quality was first addressed as a concept. The goal was to identify the components that participants would spontaneously bring to the debate when

https://doi.org/10.1080/21699763.2018.1472135 Published online by Cambridge University Press

probed to talk about quality in LTC. In a second moment in the discussion, participants were asked more specifically about their own experiences of quality assessment.

All participants acknowledged discursively the importance of discussing quality in LTC and were able to come up with definitions of what they consider quality in care. However, there is no translation into practice and quality assessment was still considered as something that is self-evident requiring no specific tools. This approach came largely in sequence of severe criticisms to the existing regulatory framework that was considered excessively focused on technical aspects and poor in what concerns involving people, both users and care staff.

6.1. A regulatory framework that measures poor quality

Despite the proliferation of publications addressing the general topic of 'quality of care' combined with LTC, little has been done in Portugal in terms of development of standardised protocols of quality measurement that can be used in a similar manner by all providers. In fact, the mandatory protocols in place are confined to elements related to technical aspects of the facilities where care provision takes place and to ratios of staff/users in the composition of the teams of carers providing formal services. Nothing is established for informal care provided within the family. The protocols for the formal sector are centrally defined, by state authorities acting in their role as regulators. Observing the set of technical requirements established in the legislation is a pre-requisite for obtaining a license to provide care.

All participants agreed that it is important to have minimum requirements in what concerns the resources that are allocated to care provision. However, these requirements, in Portugal, are seen as often excessive and out-of-touch with reality. Participants further stated that this leads to a landscape of extremely well equipped facilities that operate lacking, for example, properly trained professionals.

Quality assessment can be thought of from different perspectives. It can focus the resources available to tackle needs. It can focus the outputs of the provision against those needs. And it can focus on what the social actors involved in care provision (both users and carers) experience in the care locus. The stakeholders that have participated in the focus group shared strong criticisms towards the excessive weight of regulations dealing with the technical aspects of service provision, required to license services, alongside the absence of any consideration of what the user of the service feels and wants.

6.2. Quality as a desirable but self-evident outcome of care provision

Overall, we found among the participants in the focus group a discourse that acknowledges the importance of assessing impacts and quality, although there is a general difficulty in translating that into specific examples and tools. Naturally, one can always ask who is against quality (Dahl, 2012)? There was a general difficulty in coming up with a detailed and objective definition of what quality is in LTC. Participants associated four main ideas to the concept of quality in care: dignity; respect for people's preferences; participation in decisions; and happiness.

Dignity, according to the participants, is the consequence of respecting the older person in need of care as a citizen and a human being. Some participants voiced their worries

https://doi.org/10.1080/21699763.2018.1472135 Published online by Cambridge University Press

about the dominant approach to care provision as a question of charity. On the contrary they have emphasised the need to think about care provision as an issue of social rights. Quality, for these participants, is also about the fulfilment of human dignity, even an issue of human rights

> Care provision is a question of human rights. Quality is in the dignity of the person, it's about acknowledging the right to receiving the care each individual needs. [P1]

Participants all agreed that standardised approaches to care provision, very much fostered by the existing regulatory framework, prevent users from having their preferences considered when designing care provision plans. Participants directly involved in the organisation of care services emphasised this aspect and were able to give some examples of what this means in terms of the actual provision.

> You need to hear what people prefer. For example, what people want to eat, what time they want to go to bed … [P4]

Associated to this is the importance of participation in decision. All agreed that the user of services should be allowed to participate in the decisions about how his or her care plan is organised. They acknowledged, however, that these are tough principles to put into practice and explained that by the conditions of work of most services, with shortage of staff, bureaucratic pressures from the regulator and the high numbers of users.

Trying to wrap up the discussion on the topic of quality, participants stated quality is about being happy. When probed to explain what that means, opinions converged around the idea that the person requiring care should feel happy with the care he or she is getting to tackle his or her needs. This means according to the participants that there is no standard for defining quality as it can mean different things to different people. This was the argument used to sustain the belief that measuring quality is something that can be done even if you do not have any specific formal tools and previously designed protocols of assessment.

> Quality is there to be seen. You can see if people are happy. I know the residents in the nursing home I manage are happy. And that is what quality is about for me. [P5]

6.3. Social investment – do stakeholders know?

The term 'Social Investment' as a concept, or a policy term was not recognised by any participant. Despite the probing used by the moderator, participants could not come any close, on their own, to the notions of social investment that have been discussed in the literature when revisiting the concept. The moderator has offered the definition of SI in LTC as set out in SPRINT project, outlined in a previous section, and the participants started responding more enthusiastically to the topic. Social investment is not recognised as a concept but definitely as a phenomenon.

When challenged to find examples of what could constitute a social investment approach in LTC, participants converged to some ideas:

(a) home-help services are more cost-efficient than institutional care and can provide better quality of service because they guarantee that individuals remain in their homes, their meaningful social environment, which will improve their well-being;

https://doi.org/10.1080/21699763.2018.1472135 Published online by Cambridge University Press

(b) including health care services in the home-help services could reduce costs of care and improve efficiency and quality of care delivery rather than separating social and health care services – without using the term the participants were suggesting integration of care as a form of social investment;
(c) one participant stated that this integration is possible in the private sector (for-profit) but not allowed within the equivalent service provided by non-profits – suggesting integration of legislation;

(d) improving the life conditions of informal carers – this is mentioned in general terms. The moderator asks for examples of how to do that from a social investment perspective: training; financial compensation; increasing the scope of help done by home-help service to free time for the personal needs of informal carers.

The topic of introducing carer's allowances in the system (which does not exist) generated some discussion among participants with the representatives of informal carers highlighting that the introduction of financial benefits for informal carers cannot later be interpreted by the state as a transfer of responsibilities – implicit to the debate was the notion that the state passes on the responsibility for LTC to other stakeholders, namely non-profits and families.

Adaptation of home place to allow people to stay in their homes and avoid moving to residential care that is costlier and less appealing for the older person and family.

Providing adequate income as a means to allow people to tackle their needs. Moderator probes to get more about this idea to check if participants were thinking about personal budgets. Participants were considering general income since poverty in old age is still a big problem in the country.

7. Conclusion

The analysis indicates new avenues to why quality assessment tools and impact assessment protocols struggle to enter the current management processes of organisations in LTC. More specifically, they point to a mind-set within organisations where people are still reluctant to deal with objective and standardised tools of assessment which in turn is rooted in the belief that quality and social impacts are subjective in their nature and only meaningful when you look to the individual case.

When asked to describe their own experience, all participants state they assess their own activities to measure impacts and evaluate quality but they do not use any specific tools or protocols for that purpose. Additionally, they could not identify the need for such tools as they believe impacts and quality are self-evident.

This comes hand in hand with a shared criticism towards the excessive weight of regulations dealing with the technical aspects of service provision, required to license services. Participants have discursively agreed that consideration of what the user of the service feels and wants should be in place.

LTC policies and regulations in Portugal are described as suffering from a major flaw: they are skewed towards technical requirements which guarantee technical quality but do not necessarily generate quality of life for those using the services.

https://doi.org/10.1080/21699763.2018.1472135 Published online by Cambridge University Press

The question that many have been asking is why aren't there any significant developments in quality assessment among LTC providers in Portugal, despite the visibility of the topic, especially in the European context? The results suggest that there is no recognition among stakeholders directly involved in care provision of the terms of the discussion on quality assessment and instead rather fuzzy notions inspired by the traditional social doctrine of Third Sector organisations that reproduce ideals of doing good and individual happiness that do not have immediate translation into the material aspects of daily life.

Notes

1. The article acknowledge support to the study from the EU research project Horizon 2020, Social Investment in the LTC, SPRINT.
2. This is not part of this article, but part of a comparative article in this themed section.
3. Source: Social Security List of IPSS, http://www.seg-social.pt/publicacoes?bundleId=11899703. Last accessed on 31st of October 2017.
4. Source: http://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do (last accessed on the 31st of October 2017). See also Greve, 2017.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This work was supported by H2020 Society [grant number 649565].

Notes on contributors

Alexandra Lopes holds a PhD in Social Policy from the London School of Economics. She is the Director of the Research Centre of Sociology at the University of Porto and Senior Lecturer in the Sociology Department. Her research interests are on ageing dynamics and on social policy changes in familist social policy settings.

Isabel Dias holds a PhD in Sociology from the University of Porto. She is an Associate Professor at the Department of Sociology of the University of Porto. Her research interests are on ageing dynamics in Portugal with a focus on violence, abuse and neglect of older people.

ORCID

Lopes Alexandra http://orcid.org/0000-0002-4584-5563
Isabel Dias http://orcid.org/0000-0001-8688-4385

References

Birren, J. E., Lubben, J. E., Rowe, J. C., & Deutchman, D. E. (Eds.). (2014). *The concept and measurement of quality of life in the frail elderly*. San Diego and London: Academic Press.

Bowling, A., Banister, D., Sutton, S., Evans, O., & Windsor, J. (2002). A multidimensional model of the quality of life in older age. *Aging and Mental Health*, *6*(4), 355–371.

Bravo, G., De Wals, P., Dubois, M. F., & Charpentier, M. (1999). Correlates of care quality in long-term care facilities: A multilevel analysis. *Journal of Gerontology*, *54B*(3), P180–P188.

https://doi.org/10.1080/21699763.2018.1472135 Published online by Cambridge University Press

Dahl, H. M. (2012). Who can be against quality? A new story about home-based care: NPM and governmentality. In C. Ceci, K. Bjørnsdottir, & M. Purkis (Eds.), *Perspectives on care at home for older peope* (pp. 139–156). Oxon: Routledge.
Donabedian, A. (1988). The quality of care: How can it be assessed? *JAMA*, *260*(12), 1743–1748.
EU. (2012). *Long-term care for the elderly. Provisions and providers in 33 European countries*. Luxembourg: Publications Office of the European Union.
Ferreira, V. (2010). *Elderly care in Europe. Provisions and providers in Portugal*. External report commissioned by and presented to the EU Directorate-General Employment and Social Affairs, Unit G1 'Equality between women and men'.
Greve, B. (Eds.). (2017). *Long-term care for the elderly in Europe*. Oxon: Routledge.
Kane, R. A., & Kane, R. L. (1988). Long-term care: Variations on a quality assurance theme. *Inquiry*, *25*, 132–146.
Lopes, A. (2013). New approaches to familism in the management of social policy for old age in Portugal. In H. J. von Kondratowitz & J. Troisi (Eds.), *Ageing in the Mediterranean* (pp. 251–234). Bristol: Policy Press.
Lopes, A. (2017). LTC in Portugal: Quasi-privatization of a dual system of care. In B. Breve (Ed.), *Long-term care for the Eldferly in Europe* (pp. 59–74). Oxford: Ashgate.
Lopes, A., Glanz, A., Richards, A., Greve, B., Barbieri, D., Micharikopoulos, D., … Rutkowska, Z. (2017). Conceptual report on long-term care. *Deliverable D.2.1 SPRINT – social protection innovative investment in long-term care*. London and Brussels: SPRINT Consortium. Retrieved from http://sprint-project.eu/wp-content/uploads/2015/12/SPRINT_D.2.1_Conceptual_Report_LTC.pdf
Midgley, J., Dahl, E., & Wright, A. (Eds.). (2017). *Social investment and social welfare. International and critical perspectives*. Cheltenham: Edward Elgar.
Mor, V. (2005). Improving the quality of long-term care with better information. *The Milbank Quarterly*, *83*(3), 333–364.
Mor, V., Angelelli, J., Gifford, D., Morris, J., & Moore, T. (2003). Benchmarking and quality in residential and nursing homes: Lessons from the US. *International Journal of Geriatric Psychiatry*, *18* (3), 258–266.
Morel, N., Palier, B., & Palme, J. (Eds.). (2012). *Towards a social investment welfare state. Ideas, policies and challenges*. Bristol: Policy Press.
Paúl, C., & Fonseca, A. (Eds.). (2005). *Envelhecer em Portugal, Psicologia, Saúde e Prestação de Cuidados*. Lisbon: Climepsi.
Pereirinha, J., & Murteira, M. (2016). The Portugese welfare system in a time of crisis and fiscal austerity. In K. Schubert (Ed.), *Challenges to European welfare systems* (pp. 587–614). Heidelberg: Springer.
Petmesidou, M. (2018). Southern Europe. In B. Greve (Ed.), *The Routledge handbook of the welfare state* (2nd ed, pp. 183–192). Oxon: Routledge.
Rhodes, M. (Eds.). (1997). *Southern European welfare states. Between crisis and reform*. London: Frank Cass.
Saraceno, C. (2017). Southern European welfare regimes: From differentiation to reconvergence? In P. Kennet, & N. Lendvai-Baiton (Eds.), *Handbook of European social policy* (pp. 218–229). Chelthenham: Edward Elgar.
Vaarama, M., Pieper, R., & Sixsmith, A. (Eds.). (2007). *Care-related quality of life in old age*. New York: Springer.
Yin, R. (2014). *Case study research: Design and methods* (5th ed.). Thousand Oaks: Sage.

https://doi.org/10.1080/21699763.2018.1472135 Published online by Cambridge University Press